The Natural Health Project
555 Highway 51 Ridgeland, MS 39157

Patient Name_______________________________Date_______________________
Address: ___________________________City_______________State____Zip________
Email____❑Male ❑ Female
Birth Date_______________________________SSN_____________________________
Home Phone___________ Cell________________ Work_________________________
❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Separated No. of Children_______
Occupation____________________Employer_____________________________________
Spouse (Guardian) ____________________________ Birth Date ___________________
Occupation__________________________ SSN________________________________
Person responsible for account __________________________Relationship________
Address______________________________________ Email_______________________
Home Phone__________________ Cell Phone__________________ SSN__________
Referred by____
Have you had chiropractic care before? ❑ Yes ❑ No When?_______Dr.?___________

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN
APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **The Natural Health Project (Dr. Samuel E. Gamble, Dr. Addie H. Stanford, Dr. Haley Thomason, Chad Rhoden, M.D., Melissa Wood, FNP-BC))** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "The Natural Health Project") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to The Natural Health Project for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been*** or ***will be*** rendered or provided; as well as designating and appointing The Natural Health Project as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to The Natural Health Project all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that The Natural Health Project can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either The Natural Health Project, myself, and/or my family members as a result of services rendered by The Natural Health Project, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that The Natural Health Project is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that The Natural Health Project can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by* The Natural Health Project. A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

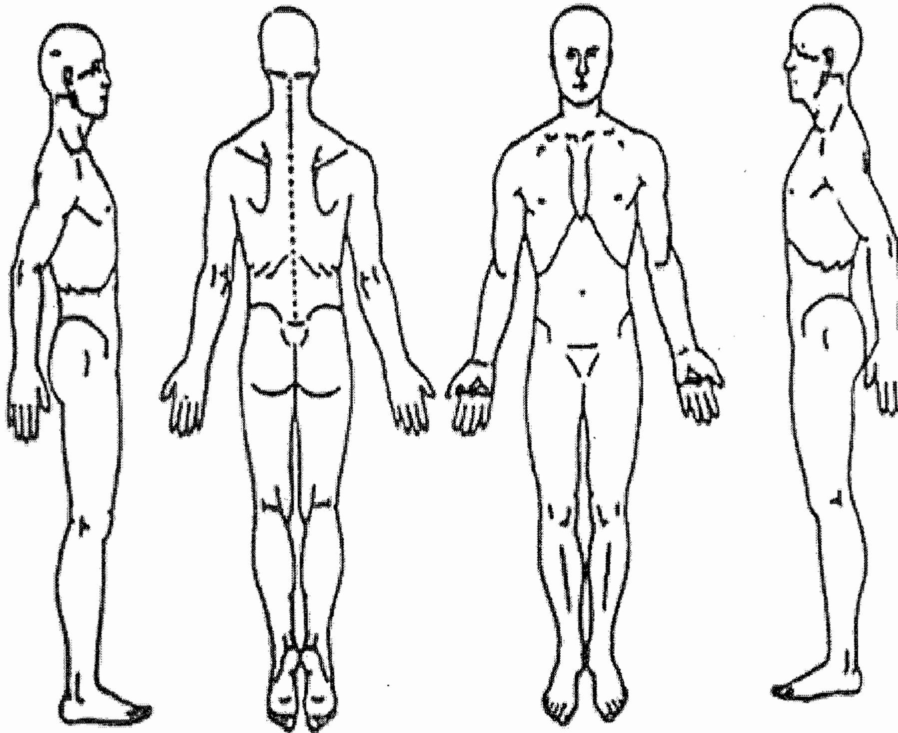
Signature ____ **Date** ______________

Symptom/ Pain Information

Please describe the health problem for which you came to our office:______________________________
____

Circle the character of your symptom(s). Burning, tingling, aching, tired, numb, sharp, dull, stabbing, shooting, radiating, other ____.

Shade in the area on the diagram where you feel discomfort or symptoms.



Please mark the scale to show how bad your usual discomfort has been recently. If you are describing more than one symptom, indicate the level of pain for each symptom.

How long have you had this episode of symptoms?____

How many times have you had a problem similar to or the same in the past?

- ❑None previously
- ❑1-5 episodes
- ❑6-10 episodes
- ❑More than 10 episodes
- ❑Single episode of continuous pain

Clinician Initial_________Date____________

When was the very first time you ever felt something similar to or the same as your current problem?
❑Less than 6 months ago ❑1-5 years ago ❑10-20 years ago
❑6 months- 1 year ago ❑5-10 years ago ❑More than 20 years ago

Did symptoms begin gradually, over time, or suddenly? ____________________

Since your symptoms began, have they ❑Improved ❑Worsened ❑Stayed the same

Are your symptoms constant? ❑Yes ❑No
If there are any times or positions when you do not experience your pain/ discomfort (e.g., after exercising, while sleeping), please explain:____________________

What caused your symptom(s) to occur (physical overuse, mental stress, accident, etc.) **BE SPECIFIC**
____
____

What aggravates your current symptoms?____________________
____

Is your sleep disturbed by these symptoms? ❑Yes ❑No

Do you sleep on a ❑Mattress/box spring ❑Waterbed ❑Futon ❑Other____________
What is your normal sleep position? ❑Back ❑Side ❑Stomach ❑Other____________

If you are restricted/limited to any work, home or recreational activities because of your discomfort, please describe____________________
____

Are your symptoms the result of an auto accident, work injury or other personal injury? ❑Yes ❑No
If you answered yes, please fill out an accident specific form, available at the front desk.

Have you done anything to try to help or relieve you complaint? ❑Rest ❑Heat ❑Cold ❑Asprin ❑Medications
❑Sitting ❑Lying down ❑Other____________________

Are you now doing corrective exercises for your present symptoms? ❑Yes ❑No Recommended by?__________
Briefly describe the exercises/stretches you are doing____________________

Do you participate in other exercises (aerobics, walking, jogging, etc.)?____________________
If yes, what type and how many times per week/month?____________________

Have you seen any other health care provider outside of this office for this problem? ❑Yes ❑ No
If yes, whom did you see?____________________ When were you seen?____________
Were x-rays taken? ❑Yes ❑No What type of treatment was done?____________________
How much did it help? (1____________________10)
No improvement Full improvement

Women Only:
Are you pregnant or think you may be pregnant? ❑Yes ❑No
Date of last menstrual period?____________________
Do you or have you suffered from any menstrual disorders? ❑Yes ❑No If yes, please descibe____________
____

Clinician Initial__________ Date__________

Health History

Have you ever had any of the following? (Circle yes or no/ leave; blank if you are uncertain)

Arteriosclerosis......... ❑Yes ❑No	Pneumonia.........❑Yes ❑No	Hemorrhoids......................❑Yes ❑No
Asthma......................❑Yes ❑No	Kidney Disease...❑Yes ❑No	Arthritis...............................❑Yes ❑No
Eczema ....❑Yes ❑No	Appendicitis.......❑Yes ❑No	Blood/Plasma Transfusion.❑Yes ❑No
Anemia...................... ❑Yes ❑No	Chicken Pox........❑Yes ❑No	Carpal Tunnel......................❑Yes ❑No
Cancer....................... ❑Yes ❑No	Smallpox............❑Yes ❑No	Scarlet Fever........................❑Yes ❑No
Diabetes....................❑Yes ❑No	Scarlette Fever....❑Yes ❑No	Infectious Mono.................❑Yes ❑No
Dizziness/ fainting......❑Yes ❑No	Diphtheria...........❑Yes ❑No	Bronchitis............................❑Yes ❑No
HIV infection..............❑Yes ❑No	Bladder Infection❑Yes ❑No	Rheumatic Fever.................❑Yes ❑No
Tuberculosis...............❑Yes ❑No	Polio ....❑Yes ❑No	Double or blurred vision....❑Yes ❑No
Epilepsy......................❑Yes ❑No	Gout....................❑Yes ❑No	Depression..........................❑Yes ❑No
Heart attack/ Disease❑Yes ❑No	Glaucoma...........❑Yes ❑No	Multiple Sclerosis................❑Yes ❑No
High Blood Pressure..❑Yes ❑No	Hernia.................❑Yes ❑No	Drug/alcohol Dependence ❑Yes ❑No
Low Blood Pressure...❑Yes ❑No	Back Surgery.......❑Yes ❑No	Ear Infection........................❑Yes ❑No
Migraines...................❑Yes ❑No	Pleurisy...............❑Yes ❑No	Stroke................................ ❑Yes ❑No
Motion Sickness.........❑Yes ❑No	TMJ......................❑Yes ❑No	Rheumatic Fever................❑Yes ❑No
Mumps.......................❑Yes ❑No	Hepatitis..............❑Yes ❑No	Allergies..............................❑Yes ❑No
Low blood Pressure....❑Yes ❑No	Thyroid Problems❑Yes ❑No	Influenza.............................❑Yes ❑No
Ulcer...........................❑Yes ❑No	Venereal Disease.❑Yes ❑No	Fatigue (Chronic)...............❑Yes ❑No
Sinus Trouble..............❑Yes ❑No	Bleeding Tendency❑Yes ❑No	Other_______________
Digestive Disorders.....❑Yes ❑No	Broken Bones.......❑Yes ❑No	

Previous Hospitalizations/Surgeries/Serious Illnesses	**When?**	**Hospital (City, State)**

Medication: (include nonprescription)

____

____

Allergies:____

Have you ever taken Fen-Phen/Redux? ❑Yes ❑No

Are you taking any medications (prescription or over the counter) for acid indigestion? ❑Yes ❑No

If yes, what type?____

Pharmacy Name:____

Address______________________ Phone Number______________________

Patient Social History

Marital Status	❑Single	❑Married	❑Separated	❑Divorced	❑Widowed
Use of alcohol	❑Never	❑Rarely	❑Moderate	❑Daily	
Use of tobacco	❑Never	❑Rarely	❑Moderate	❑Daily	
Use of drugs	❑Never	Type/Frequency:______________			
Excessive exposure					
At home or at work to:	❑Fumes	❑Dust	❑Solvents	❑Airborne Particles	❑Noise

Clinician Initial__________Date____________

Family Medical History:

	Age	Disease	If deceased, cause of death
Father			
Mother			
Siblings			
Spouse			
Children			

Indicate which of the below you have experienced in the last 1-2 months
1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Eyes/Ears/Nose/Throat/Respiratory		**Muscular/Skeletal**	
Asthma	1 2 3 4 5	Muscle Aches	1 2 3 4 5
Stuffy Nose	1 2 3 4 5	Fibromyalgia	1 2 3 4 5
Hay Fever	1 2 3 4 5	Arthritis	1 2 3 4 5
Sore throat	1 2 3 4 5	Joint Pain	1 2 3 4 5
Chronic Cough	1 2 3 4 5	Low Back Pain	1 2 3 4 5
Chest Congestion	1 2 3 4 5	Neck Pain	1 2 3 4 5
Frequent Sneezing	1 2 3 4 5	Wrist/Hand Pain	1 2 3 4 5
Itchy/Watery Eyes	1 2 3 4 5	Elbow Pain	1 2 3 4 5
Drainage	1 2 3 4 5	Shoulder Pain	1 2 3 4 5
Earache or Ear Infection	1 2 3 4 5	Hip Pain	1 2 3 4 5
Itching	1 2 3 4 5	Knee Pain	1 2 3 4 5
Hoarseness	1 2 3 4 5	Ankle/Foot Pain	1 2 3 4 5
Shortness of Breath	1 2 3 4 5	Pain b/t shoulder blades	1 2 3 4 5
Wheezing	1 2 3 4 5		

Neurological		**General**	
Headaches	1 2 3 4 5	Fatigue	1 2 3 4 5
Migraines	1 2 3 4 5	Malaise	1 2 3 4 5
Dizziness	1 2 3 4 5	Weakness, tiredness	1 2 3 4 5
Numbness	1 2 3 4 5	Lightheadedness	1 2 3 4 5
Tingling	1 2 3 4 5	Irritability	1 2 3 4 5
Pins/needles in hands or feet	1 2 3 4 5	Constipation	1 2 3 4 5
		Diarrhea	1 2 3 4 5
		Feeling foggy	1 2 3 4 5
		Forgetfulness	1 2 3 4 5

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

______________________________ ________________

Signature of the Patient, Parent or Guardian Date

NEUROLOGICAL AND VASCULAR PATIENT QUESTIONNAIRE

NAME:________________________________ DATE:________________

For any YES answer, please notify the Doctor.

1. Do you suffer from neck pain with pain in your shoulder, arms or hands? NO YES
   Comment:____
2. Do you have weakness, numbness or burning in your shoulder, arms or hands? NO YES
   Comment:____
3. Do your hands or arms fall asleep regularly? NO YES
   Comment:____
4. Do you have reduced feeling (sensation) or swelling in your hands or arms? NO YES
   Comment:____
5. Do you suffer from a loss of handgrip strength? NO YES
   Comment:____
6. Do you suffer from back pain with pain in your buttocks, legs or feet? NO YES
   Comment:____
7. Do you have weakness, numbness or burning in your buttocks, legs or feet? NO YES
   Comment: ____
8. Do your legs or feet fall asleep regularly? NO YES
   Comment:____
9. Do you have reduced feeling (sensation) or swellings in your legs, feet? NO YES
   Comment:____
10. Do you suffer from cold hands or feet? NO YES
    Comment:____
11. Do you suffer from headaches, dizziness or memory loss? NO YES
    Comment:____
12. Do you have difficulty maintaining your balance? NO YES
    Comment:____
13. Do you suffer from vertigo or blurred vision? NO YES
    Comment:____
14. Do you suffer from a reduced hearing capacity? NO YES
    Comment:____
15. Do you suffer from ringing in your ears? NO YES
    Comment:____
16. Do you have bladder or bowel control problems on a regular basis? NO YES
    Comment:____

THE NATURAL HEALTH PROJECT
CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic manipulation and manual therapy techniques and other chiropractic procedures, including various modes of physical therapeutic modalities and procedures and diagnostic X-rays, where warranted, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below.

I have had an opportunity to discuss with the doctor of chiropractic named below the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment and diagnostic services including but not limited to:

Manipulation: increased pain or discomfort, fractures, disc injuries, strokes, dislocations and sprains.

Therapeutic Modalities and procedures: additional pain and discomfort. Endurance exercise may cause increased risk of acute Myocardial Infarction (heart attack) in patients with known or possible cardiac conditions.

Radiographs: ionizing radiation can be harmful to a fetus for those who are pregnant or might be pregnant.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. The doctor named below has additionally explained the risks associated with my refusal of treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient/Guardian Signature________________________ Date ________________

Witness Signature ______________________________ Date____________